BOARD OF CHIROPRACTIC MEDICINE

GENERAL INFORMATION/INSTRUCTIONS
REGISTERED CHIROPRACTIC ASSISTANT TO MODIFY SUPERVISOR

HOW TO APPLY FOR FLORIDA LICENSURE

***** PLEASE TYPE OR PRINT IN BLACK INK - PLEASE READ CAREFULLY *****

1. FLORIDA LAWS & RULES:

You may download a copy of Section 460, Florida Statutes and Rule Chapter 64B2, Florida Administrative Code at www.doh.state.fl.us/mqa/chiro/index.html It is important to read this in order to determine your eligibility prior to applying, and to familiarize yourself with the statutes and board rules regarding your application for licensure.

2. FEE SCHEDULE:

Registration Fee	$25.00 (non-refundable)
Unlicensed Activity Fee	$ 5.00
Total:	**$30.00**

NOTE: A FEE OF $30.00 MUST BE INCLUDED WITH **EACH** APPLICATION.
PLEASE PROVIDE SEPARATE PAYMENTS FOR MULTIPLE APPLICATIONS.

3. RETURN APPLICATION AND FEES TO: (certified check or money order).

Department of Health
Post Office Box 6330
Tallahassee, Florida 32314-6330

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health
Board of Chiropractic Medicine

Name:

_____

Last **First** **Middle**

Social Security Number:

_____

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

BOARD OF CHIROPRACTIC MEDICINE
Application for
Registered Chiropractic Assistant to Modify Supervisor (RCA)
(Client: 502)

Fees: (8075)

Please complete form and return the fees (certified check or money order) to the address below. Also print legibly or type the information.

Registration Fee:	$25.00
Unlicensed Activity Fee:	$ 5.00
Total Fee:	**$30.00**

1. APPLICATION PROFILE DATA: (completed by RCA Applicant)

(Name) Last First Middle

(Mailing Address) Street Number Apt/Suite Number

City State Zip Code

( ) ( )
Home Telephone Number Business Telephone Number

Date of Birth Place of Birth (City/State/Country)

Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name?

_____ Yes _____ No
If yes, list name(s) and date(s) of change below:

What country are you a citizen of? _____

E-mail Address: _____

RCA License Number: _____

2. PLEASE INDICATE YOUR REQUEST(S): [Attach additional sheet(s) if necessary]

I am ADDING this supervisor: _____ CH _____

I am REMOVING this supervisor: _____ CH _____
Supervisor's Name License Number

Applicants Name: _____

3. LIST ALL FUNCTIONS THAT YOU WILL BE PERFORMING:
(Use back of page or attach additional sheet(s) if necessary)

_____

_____

_____

_____

4. EMPLOYER/SUPERVISOR PROFILE DATA:
(To be completed by Chiropractic Physician or Certified Chiropractic Physician's Assistant)

_____
(Name) Last First Middle

_____
(Physical Location Address) Street Number Apt/Suite Number

_____
City State Zip Code

(___) _____ (___) _____
Home Telephone Number Business Telephone Number

_____ _____
Date of Birth License Number

APPLICANT SIGNATURE

I hereby authorize all hospitals, institutions, organizations, my references, personal physicians, employers (past and present), all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department of Health, any information, files or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, individuals and groups listed above any information which is material to my application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare, that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such acts shall constitute cause for the denial, suspension or revocation of any license to practice in the State of Florida, the profession for which I am applying.

_____
Assistant Signature (required) Date Signed

_____
Supervisor Signature (required) Date Signed

THIS REGISTRATION IS VALID ONLY WHILE PERFORMING THE DUTIES LISTED ABOVE UNDER THE DIRECT SUPERVISION OF THE ABOVE SIGNED CHIROPRACTIC PHYSICIAN.